Fax#: (801) 288-5342 ***FUNCTIONAL ABILITY EVALUATION MEDICAL REPORT*** UTAH DRIVER LICENSE DIVISION

TOP PORTION MUST BE COMPLETED BY APPLICANT

P O BOX 30560
SLC UT 84130-0560
(801) 965-4437 www.driverlicense.utah.gov

Last Name **First Name** **Middle or Maiden Name** **Date of Birth** **Driver License Number**

As part of my application for driving privileges, the following information about my physical, mental and emotional health is submitted. Report below anything which might affect driving, such as seizures, heart attacks, use of alcohol or other drugs, psychiatric conditions, accidents, visual loss, etc. Give date(s) of last occurrence(s) and any medications being used:_____

I authorize any health care professional to release information pertaining to my physical, mental and emotional health for private confidential use in my evaluation for driving privileges. I expect the health care professional to advise me about my health as it relates to driving and to report accurately regarding my condition, but I understand the Department of Public Safety is responsible for all decisions about issuing driver licenses and medical certificates. I further understand it is my responsibility to refrain from driving if I become aware of changes in my health, which may affect driving safety and report relevant changes in writing to the Driver License Division.

Date: _____ **APPLICANT'S SIGNATURE:**_____

Commercial Intrastate drivers (Class A, B, C Licenses) must be profiled in ALL categories by the examining health care professional.

HEALTH CARE PROFESSIONAL REPORT BELOW

The following functional ability profile is for use in determining driving privileges. It is consistent with **Functional Ability in Driving: Guidelines and Standards for Health Care Professionals.** Details are found in the 2000 edition of the Guidelines and Standards. Please mark profile below with a horizontal line or an "X" to show appropriate level for each category. In some categories, final level may depend upon driving test. Please check the box below to indicate that a driving test should be taken.

Profile Level	A Diabetes & Metabolic Condition	B Cardio-Vascular & High Blood Pressure	C Pulmonary ☐ Inhaler Only ☐ Inhaler & Meds	D Neurologic	E Epilepsy Or Episodic Conditions	F Learning Memory	G Psychiatric Or Emotional Condition	H Alcohol & Other Drugs	J Musculo-skeletal/ Chronic Debility	K Alertness or Sleep Disorders	L Hearing ☐ Balance ☐
1											
2					K MAB C						
3			K	K			K	K	K MAB C	K MAB C	
4	K					K			MAB P	D***	
5						Not Used				S*A**D***	K
6		S*A**D***	S*A**D***	S*A**D***	S*A**D***	S*A**D***	S*A**D***	S*A**D***	S*A**D***	Not Used	Not Used
7	S*A**D***										
8											

If it is not possible to complete all categories, please check one of the following:

☐ Non-standard review time frame_____
☐ Profile categories not marked are not relevant to driving ability in this case (e.g. visual problem only)
☐ Profile categories not marked are relevant and should be completed by another health care professional
☐ There are special considerations I would like to discuss with a representative of the Department or the Medical Advisory Board.
☐ I have not examined this patient recently or completely enough to have a valid judgment.
☐ **I recommend that this driver complete a driving skills test in an appropriate vehicle.**

Recommended Restrictions:
☐ Speed* ☐ Daylight only***
☐ Area** ☐ None
☐ Accompanied by licensed driver
K = for Division use only P= Private
MAB = Medical Advisory Board C= Commercial

Date **Printed Name of Primary Physician and Degree** **Signature** **State License Number**

Street Address **City** **State** **Zip Code** **Telephone** **Fax Number**

Doctor's Comments_____

Date **Printed Name of Other Health Care Professional (If Applicable)** **Signature** **State License Number**

Street Address **City** **State** **Zip Code** **Telephone** **Fax Number**

Doctor's Comments_____

Date **Printed Name of Other Health Care Professional (If Applicable)** **Signature** **State License Number**

Street Address **City** **State** **Zip Code** **Telephone** **Fax Number**

Doctor's Comments_____